

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

VECTIBIX (panitumumab)

Patient name: _____ Medicaid or SS# _____

Physician Name: _____ Contact person: _____

Phone#: _____ Ext and options _____ Fax# _____

Physician NPI: _____

Diagnosis _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN A LETTER OF
MEDICAL NECESSITY**

CRITERIA:

- ▶ Minimum age - 18 years old
- ▶ Diagnosis of metastatic colorectal cancer.
- ▶ Disease progression on or following fluoropyrimidine-, oxplatin-, and irinotecan-containing chemotherapy regimens.

INFORMATION:

To be given in clinic setting only. Patients with HMO's (except IHC) will have to make arrangements with their HMO for coverage. Provider will bill with J code J9999, NDC number, and PA number.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Updated letter of medical necessity.